VI. PROVIDER EXCLUSIONS, SUSPENSIONS AND TERMINATIONS

A. Scope and Purpose

1. *This section specifies which individuals and entities may, or in some cases must, be excluded from the TRICARE program. It outlines the authority given to the Department of Health and Human Services/Office of Inspector General (DHHS/OIG) to impose exclusions from all Federal health care programs, including TRICARE. This section also outlines the TRICARE Management Activity (TMA) authority for exclusions and terminations. In addition, this section states the effect of exclusion, factors considered in determining the length of exclusion, and provisions governing notices, determinations, and appeals.*

2. *This section is applicable to and binding on TMA and its managed care contractors.*

3. *Service Point of Contacts do not have the authority to overturn a TMA or DHHS exclusion.*

Note:

For definitions of the terminology used in this section, refer to OPM Part Two, Chapter 11.

B. Provisions for Exclusions, Suspensions and Terminations

1. Authority for Sanctioning Providers

a. 32 CFR 199.9

32 CFR 199.9 provides for administrative remedies available to TMA for provider exclusions, suspensions, and/or terminations. The Director, TMA, or a designee, shall have the authority to exclude, suspend, and/or terminate an authorized TRICARE provider.

b. Health Insurance Portability and Accountability Act (HIPAA) of 1996, Public Law 104-191

HIPAA sets forth the DHHS/OIG's exclusion and civil money penalty authorities (CMP). HIPAA expanded the minimum mandatory exclusion authority; established minimum periods of exclusion; established a new permissive exclusion authority; and extended the application of CMP provisions to include all Federal health care programs. In addition, HIPAA strengthened and revised the DHHS/OIG's existing CMP authorities.

c. The Balanced Budget Act of 1997 (BBA)

The BBA fraud and abuse provisions serve to strengthen the DHHS/OIG's exclusion and CMP authority with respect to Federal health care programs. The BBA enables the DHHS/OIG to direct the imposition of exclusions from all Federal health care programs.

C. DHHS/OIG Application of Sanction Authority

1. Exclusions

a. Mandatory Exclusions

(1) *DHHS/OIG will exclude the following individuals or entities from participation in any Federal health care program:*

(a) *Felony conviction of program related crimes.*

(b) *Felony conviction related to patient abuse.*

(c) *Felony conviction relating to health care fraud.*

(d) *Felony conviction related to controlled substance.*

(2) *DHHS/OIG authority for mandatory exclusion applies where the criminal offense on which the conviction is based took place after August 21, 1996, and the conviction took place after January 1, 1997. DHHS/OIG authority does not apply if both conditions are not met. In these cases, TMA Program Integrity Office must initiate action to exclude.*

(3) *Mandatory exclusions initiated by DHHS/OIG are for a minimum of five (5) years. Aggravating factors may be considered as a basis for lengthening the period of exclusion.*

b. Permissive Exclusions

(1) *DHHS/OIG may exclude the following individuals or entities from participation in any Federal health care program:*

(a) *Misdemeanor conviction related to fraud, theft, embezzlement, breach of fiduciary responsibility or other financial misconduct.*

(b) *Misdemeanor conviction related to obstruction of an investigation.*

(c) *Misdemeanor conviction of a controlled substance.*

(d) *License revocation/suspension or default on a health education loan/scholarship obligation.*

(e) *Fraud, kickbacks, and other prohibited activities.*

(f) *Entities controlled by a sanctioned individual or individuals controlling a sanctioned entity.*

(g) *Claims for excessive charges or unnecessary services and failure of certain organizations to furnish medically necessary services. Certain organizations include health maintenance organizations, other entities given special medicare approved waivers, and eligible organizations under a risk sharing Medicare contract.*

(h) *Exclusion or suspension under a Federal or State health care program.*

(2) *DHHS/OIG authority for permissive exclusions applies where the action (e.g., conviction, license revocation, etc.) took place after August 21, 1996, under Federal or State law. DHHS/OIG authority does not apply if this condition is not met. In these cases, TMA Program Integrity Office may initiate action to exclude.*

(3) *Permissive exclusions initiated by DHHS/OIG are for no less than one (1) year. Aggravating factors may be considered as a basis for lengthening the period of exclusion.*

c. *The contractor is required to provide written notice to TMA Program Integrity Office of any situation involving a TRICARE provider who meets the criteria under the mandatory or permissive exclusion authority granted DHHS/OIG.*

d. *TMA Program Integrity Office is responsible for requesting DHHS/OIG initiate mandatory and permissive exclusions of TRICARE providers and will provide appropriate documentation needed to initiate separate sanction action (e.g., indictment, plea agreement, conviction document, sentencing document).*

e. *TMA Program Integrity Office will advise DHHS/OIG of TRICARE imposed sanctions and is responsible for supplying DHHS/OIG with the appropriate documentation needed to initiate separate sanction action.*

2. Notice, Effective Date, Period of Exclusion, and Appeals Process

DHHS/OIG has sole responsibility for issuing a written notice of its intent to exclude a provider or entity, the basis for the exclusion, the effective date, the period of exclusion, and the potential effect of exclusion. DHHS/OIG will handle appeal of exclusions under Section VI.C.

3. Requests for Reinstatement

DHHS/OIG has sole authority for terminating an exclusion imposed under their authority. DHHS/OIG will handle notifications of approval/denial of a request for reinstatement and are responsible for reversing or vacating decisions.

4. Program Notification of Exclusion/Reinstatement

DHHS/OIG exclusions and reinstatements are issued on a monthly basis. DHHS/OIG will provide TMA Program Integrity Office with immediate access to this information via disk, which will then be forwarded to each contractor.

5. Scope and Effect of the Exclusion

Exclusions taken by DHHS/OIG are binding on Medicare, Medicaid, and all Federal health care programs. No payment will be made for any item or service furnished on or after the effective date of exclusion until an individual or entity is reinstated by DHHS/OIG, and subsequently meets the requirements under 32 CFR 199.6.

D. TMA Application of Sanction Authority

1. Sanction Authority

a. *TMA may exclude any individual or entity based on:*

(1) *Civil fraud involving TRICARE.*

(2) *Administrative determination of fraud and/or abuse under TRICARE.*

(3) *Revocation of provider credentials through the Veterans Administration or Military Department credentials review process.*

(4) *Determination that the provider participated in a conflict of interest situation or received dual compensation.*

(5) *Violation of participation agreement or reimbursement limitations.*

(6) *Institutional providers who practice discrimination in violation of Title VI, of the Civil Rights Act of 1964.*

(7) *Administrative determination that it is in the best interests of TRICARE or TRICARE beneficiaries. Examples include unethical or improper practices or unprofessional conduct by a TRICARE provider; a finding that the provider poses a potential for fraud, abuse, or professional misconduct; the provider poses a potential harm to the financial or health status of TRICARE beneficiaries.*

b. *The contractor is required to provide written notice to TMA Program Integrity Office of any situation involving a TRICARE provider who meets the criteria under the TMA sanction authority.*

2. *Period of Exclusion/Suspension*

The Director, TMA or designee, has the authority to exclude or suspend an authorized TRICARE provider. The period of exclusion is at the discretion of TMA.

3. *Notice of Exclusion Action*

The TMA Program Integrity Office has sole authority for issuing notification of exclusion action. The TMA Program Integrity Office will send written notice of its intent, the basis for the proposed exclusion, and the potential effect of exclusion. The individual or entity may submit evidence and written argument concerning whether the exclusion is warranted. The TMA Program Integrity Office also has sole authority to issue an Initial Determination of Exclusion. Written notice of this decision will include the basis for the exclusion, the length of the exclusion, as well as the effect of the exclusion. The determination also outlines the earliest date on which the TMA Program Integrity Office will consider a request for reinstatement, the requirements for reinstatement, and appeal rights available. The TMA Program Integrity Office will notify appropriate agencies, to include contractors, of all exclusion actions taken. The TMA Program Integrity Office will be responsible for initiating action based on reversed or vacated decisions.

4. *Effect of the Exclusion*

Exclusion of a provider or entity shall be effective fifteen (15) calendar days from the date of the Initial Determination. The contractor is responsible for ensuring that no payment is made to a sanctioned provider or entity for care provided on or after the date of the TMA action. The contractor must also ensure that a sanctioned provider or entity is not

included in the network and that appropriate steps are taken to notify appropriate parties of exclusion action taken by TMA as outlined in paragraph E of this section.

5. Request for Termination of Exclusion

The Director, TMA or designee has sole authority for approval of any request for termination of an exclusion action. TMA Program Integrity Office will consult the contractor concerning any amounts owed prior to reinstatement of an excluded provider or entity.

6. Provider Termination

Administrative remedies are available to the Director, TMA or designee, as well as contractors, for initiating termination action. TMA Program Integrity Office will terminate the authorized provider status of any provider or entity determined not to meet program requirements only in circumstances where exclusion is also warranted. A provider or entity shall submit a written request for reinstatement to TRICARE. The request for reinstatement will be processed under the procedures established for initial requests for authorized provider status. See Section VII. of this chapter for further information.

7. Other Listings

As identified, other listings of actions affecting provider authorization status (e.g., Federation of State Medical Boards of the United States) will be sent to each contractor. A provider who has licenses to practice in two or more jurisdictions and has one or more licenses suspended or revoked shall be terminated as a TRICARE provider in all jurisdictions.

E. Contractor Application of Sanction Authority

Contractors shall ensure the enforcement of all sanction action taken, notify appropriate parties and its effect upon payment by TRICARE for any services provided or received.

1. Contractor Actions under DHHS/OIG Exclusion Authority

a. *The contractor is required to provide written notice to TMA Program Integrity Office of any TRICARE provider who meets the criteria under the mandatory or permissive exclusion authority granted DHHS/OIG. The notice must include appropriate documentation relevant to the situation (e.g., notice of license revocation, notice of a misdemeanor convictions, etc.).*

b. *The contractor will be provided immediate access to the monthly issuance of DHHS/OIG exclusion and reinstatement actions and is responsible for:*

(1) *Ensuring that no payment is made to a sanctioned provider or entity for care provided on or after the date of the DHHS/OIG action. Neither the provider, entity, nor the patient will be entitled to TRICARE cost-sharing once the exclusion is effective. The contractor must notify TMA Program Integrity Office should a provider or entity attempt to bill the program after the effective date of exclusion. It will not be necessary for the contractor to issue a separate letter notifying the provider of the sanction action.*

(2) *Ensuring that a sanctioned provider or entity is not included in the network. If cancellation of a network provider agreement is required, the contractor shall ensure that the network provider whose contract has been cancelled clearly understands his/her status. This shall be accomplished by providing notice, by certified mail, return receipt requested, that the network provider's agreement has been cancelled.*

(3) *Issuing a special beneficiary notice (Figure 2-7-A-10) for claims having a date of service following the effective date of the DHHS/OIG exclusion. The contractor shall also ensure that proper notification is given to all Health Benefit Advisors within the provider's service area (approximately one hundred (100) miles). Lead Agent staff in the geographical area(s) of the provider's practice shall also be given notice of sanction action taken.*

(4) *Initiating appropriate reinstatement action. DHHS/OIG will advise on the monthly listing if and when a previously sanctioned provider is reinstated. That is the date that the contractor is to use for reinstatement. The contractor does not need to advise the provider of the reinstatement by DHHS/OIG, but will be responsible for ensuring that the provider or entity meets the regulatory requirements as an authorized TRICARE provider. See OPM Part Two, Chapter 7, Section VII., Provider Reinstatements, for additional guidance. The same agencies originally advised of sanction shall also be notified of the reinstatement.*

2. *Contractor Actions Under TRICARE Exclusion Authority*

a. *The contractor is required to provide written notice to TMA Program Integrity Office of any TRICARE provider who meets the criteria under the exclusion authority granted TRICARE. The notice must include appropriate documentation relevant to the situation (e.g., provider poses unreasonable potential for fraud).*

b. *The contractor will be notified immediately of an exclusion action taken by the TMA Program Integrity Office and is responsible for:*

(1) *Ensuring that no payment is made to a sanctioned provider or entity for care provided on or after the date of the TMA action. Neither the provider, entity, nor the patient will be entitled to TRICARE cost-sharing once the exclusion is effective. The contractor must notify TMA Program Integrity Office should a provider or entity attempt to bill the program after the effective date of exclusion. It will not be necessary for the contractor to issue a separate letter notifying the provider of the sanction action. However, notice of sanction action taken by TMA shall be given to all Health Benefit Advisors located within the provider's service area (approximately one hundred (100) miles) of the practice address of the excluded provider. Lead Agents in the geographical area(s) of the provider's practice shall also be given notice of sanction action taken.*

(2) *Ensuring that a sanctioned provider or entity is not included in the network. If cancellation of a network provider agreement is required, the contractor shall ensure that the network provider whose contract has been cancelled clearly understands his/her status. This shall be accomplished by providing notice, by certified mail, return receipt requested, that the network provider's agreement has been cancelled.*

(3) *Issuing a special notice to any beneficiary who submits a claim or for whom a claim is submitted, which includes services involving a sanctioned*

provider. The notice may be enclosed with the EOB, whether the claim is payable or not, or a separate letter may be sent. The substance of the message should be similar to the example shown under Figure 2-7-A-10.

(4) Initiating appropriate action, as instructed, following reversed or vacated decisions issued by the TMA Program Integrity Office or termination of sanction action by TMA. The same agencies originally advised of sanction shall also be notified of the reinstatement.

3. Contractor Requirements for Terminating a Provider

When a provider's status as an authorized TRICARE provider is ended, the contractor will initiate termination action based on a finding that the provider or entity does not meet the qualifications to be an authorized provider.

NOTE:

Separate termination action by the contractor will not be required for a provider or entity sanctioned under the exclusion authority granted DHHS/OIG.

a. Period of Termination

The period of termination will be indefinite and will end only after the provider or entity has successfully met the established qualifications for authorized provider status under TRICARE and has been reinstated under TRICARE.

b. Notice of Proposed Action to Terminate

The contractor shall notify the provider in writing of the proposed action to terminate the provider's status as an authorized TRICARE provider when the provider falls within the contractor's certifying responsibility and the provider fails to meet the requirements of 32 CFR 199.6 (Figure 2-7-A-11). The provider is not to be terminated when he/she fails to return certification packets. Such providers will be flagged as "inactive" (See OPM Part Two, Chapter 7, Section VI.E.3.d.). Do not send a copy of the proposed notice to the TMA Program Integrity Office. The notice will be sent to the provider's last known business/office address, or home address if there is no known business/office address.

(1) The notice shall state that the provider will be terminated as of the effective date of the sanction action. The notice shall also inform the provider of the situation(s) or action(s) which form the basis for the proposed termination.

(2) For network providers, the notice shall inform the provider that his/her patients will be referred to another provider pending final action.

(3) The notice shall offer the provider an opportunity to respond within thirty (30) days from the date of the notice. An extension to sixty (60) days may be granted if a written request is received during the thirty (30) days showing good cause. The provider may respond with either documentary evidence and written argument contesting the proposed action or a written request to present in person evidence or argument to a contractor's designee at the contractor's location. Expenses incurred by the provider are the responsibility of the provider.

(4) *Once the notice of proposed action to terminate is sent, the provider's claims will be suspended from claims processing until an Initial Determination is issued. The provider will be notified via the proposed notice that the claims will be suspended from claims processing. However, beneficiaries will not be notified of the suspension.*

(5) *If the provider being terminated is a Primary Care Manager (PCM), the contractor shall assist Prime enrollees with selecting a new PCM. The contractor is also responsible for assuring that the patient's medical records are transferred to the new PCM.*

c. Initial Determination

If after the provider has exhausted, or failed to comply with the procedures for appealing the termination, and the decision to terminate remains unchanged, the contractor shall invoke an administrative remedy of termination by issuing a written notice of the Initial Determination via certified mail. A copy of the Initial Determination will be sent to TMA Program Integrity Office along with supporting documentation. The Initial Determination shall include:

(1) *A unique identification number indicating the fiscal year of the Initial Determination, a consecutive number within that fiscal year and the contractor's name. A sample letter is found at Figure 2-7-A-12.*

(2) *A statement of the sanction being invoked and the effective date of the sanction. The effective date shall be the date the provider no longer meets the regulatory requirements. If there is no documentation the provider ever met the requirements, the effective date will be either June 10, 1977 (the effective date of the Regulation) or the date on which the provider was first approved, whichever date is later.*

(3) *A statement of the facts, circumstances, and/or actions that forms the basis for the termination and a discussion of any information submitted by the provider relevant to the termination.*

(4) *A statement of the provider's right to appeal. There must be a disputed issue of fact in order for an appeal to be accepted.*

(5) *The requirements and procedures for reinstatement.*

d. Providers Failing to Return Recertification Documentation

Providers failing to return recertification documentation shall not be terminated but will be placed on the "inactive" provider listing. The contractor shall first verify that the recertification package was mailed to the correct address and was not returned by the U.S. Post Office. The provider's file shall be flagged to deny claims for services regardless of who submits the claim. The provider shall be advised that such action will be taken (Figure 2-7-A-13). Refer to OPM Part Two, Chapter 7, Section II. regarding development of possible fraud cases.

e. Requirement to Recoup Erroneous Payments

After the Initial Determination has been sent, the contractor shall initiate recoupment for any claims cost-shared or paid for services or supplies furnished by the provider on or after the effective date of termination, even when the effective date is

retroactive, unless a specified exception is provided by 32 CFR 199. This applies to claims processed by previous contractors as well. All monies paid by previous contractors and recouped by the current contractor will be refunded to TMA Finance and Accounting Office. Refer to OPM Part One, Chapter 4.

f. Cancellation of Network Provider Agreements

The contractor shall ensure that a network provider whose contract has been cancelled clearly understands his/her status, and shall initiate termination action if required. This shall be accomplished by providing notice, by certified mail, return receipt requested, that the network provider's agreement has been cancelled. Cancellation of a network provider contract and termination of a TRICARE provider are to be handled as two (2) separate and distinct actions.

4. File Requirements for a Terminated Provider

The Initial Determination file shall only include documentation that is releasable to the provider. This file should also include:

a. *Initial Determination of Termination Action as well as Proposed Notice to Terminate.*

b. *Provider certification file (i.e., the documentation upon which the original certification of the provider was based).*

c. *All correspondence and documentation relating to the termination. Copies of the enclosures must be attached to the copy of the original correspondence.*

d. *Documentation that the contractor considered or relied upon in issuing a Determination.*

5. Special Action/Notice Requirements When an Institution is Terminated

When a TMA determination is made that an institutional provider does not meet qualifications or standards to be an authorized TRICARE provider, the contractor shall take appropriate action.

a. Provider and Beneficiary Notification

The contractor shall:

(1) *Instruct the institution by certified mail to immediately give written notice of the termination to any TRICARE beneficiary (or his/her parent, guardian, or other representative) admitted to or receiving care at the institution on or after the effective date of the termination.*

(2) *When the termination effective date is after the date of the initial determination, notify by certified mail any beneficiary (or their parent, guardian, or other representative) admitted prior to the date of the termination and that TRICARE cost-sharing ended as of the termination date. Advise the beneficiary (or their parent, guardian, or other representative) of their financial liability.*

(3) *If an institution is granted a grace period to effect correction of a minor violation, notify any beneficiary (or his/her parent, guardian, or other*

representative) admitted prior to the grace period of the violation and that TRICARE cost-sharing of covered care will continue during that period. (Cost-sharing is to continue through the last day of the month following the month in which the institution is terminated.)

(4) In addition, notify any beneficiary (or their parent, guardian, or other representative) admitted prior to a grace period of the institution's corrective action, when such has been determined to have occurred, and the continuation of the institution as an authorized TRICARE provider.

(5) For a beneficiary admitted during a grace period, cost-share only that care received after 12:01 a.m., on the day written notice of correction of a minor violation was received or the day corrective action was completed.

b. Cost-Sharing Actions

The contractor shall:

(1) Deny cost-sharing for any new patient admitted after the effective date of the termination.

(2) Deny cost-sharing for any beneficiary admitted during a grace period granted an institution involved in a minor violation.

(3) Deny cost-sharing for any beneficiary already in an institution involved in a major violation beginning with the effective date of the termination.

(4) Cost-share covered care for those beneficiaries admitted prior to a grace period.

6. Requests for Reinstatement

See OPM Part Two, Chapter 7, Section VII., Provider Reinstatements.

F. Contractor Actions in Cases Involving Potential Violations by Providers

Upon receipt of a complaint that an institution may be violating a TRICARE requirement, the contractor shall take the following actions:

1. In any case when it comes to a contractor's attention that a facility may not be in compliance with TRICARE requirements, TMA Program Integrity Office shall be notified immediately. Complaints of violations in hospitals and skilled nursing facilities shall be fully documented by the contractor and forwarded to TMA Program Integrity Office.

2. A detailed description of the suspected violation must be obtained by the contractor from the source of the complaint. The names of all TRICARE beneficiaries known or believed to be currently in the facility shall be included with the contractor's report of the complaint.

3. TMA Program Integrity Office may request the contractor to conduct an on-site evaluation of a specific facility or to assist in conducting such a facility review. Specific instructions will be provided when participation in an on-site evaluation is required.

G. Violation of the Participation Agreement or Reimbursement Limitation

1. *The contractor is responsible to ensure that providers adhere to their participation agreements and the reimbursement limitation. Corrective action is required for a provider who submits participating claims but does not honor the agreement to accept as the full charge the amount the contractor determines to be the allowable charge for the service or the provider who violates the one hundred fifteen percent (115%) reimbursement limitation. Beneficiary complaints about breach of the allowable charge participating agreement or reimbursement limitation shall be resolved by the contractor staff, e.g., explaining to the provider the commitment made in accepting participation or regarding the Appropriations Act. For violations involving institutional providers, the letter should be addressed by name to the hospital administrator. The contractor shall get assurance that the provider will identify and refund any money inappropriately collected and refrain from billing beneficiaries for the reductions on participating claims or in violation of the one hundred fifteen percent (115%) reimbursement limitation in the future. (See Figure 2-7-A-14, Figure 2-7-A-15, Figure 2-7-A-16 and Figure 2-7-A-17).*

2. *If after two (2) notices a provider refuses to make refunds, continues to violate participation agreements or reimbursement limitations, or brings suit against beneficiaries who refuse to pay the amount of the reduction, the contractor shall bring the matter to the attention of the TMA Program Integrity Office. The contractor shall also submit a copy of all supporting documents. This includes claims, EOBs, educational letters to the provider, patient's canceled check copy or provider's billing statement.*

3. *The contractor shall follow the same procedures listed above for those providers signing special TRICARE participating provider agreements (RTCs, PHPs, SURRFs and MFCCs).*